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Developing a Multidisciplinary Team in Primary Care

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DEVELOPING A MULTIDISCIPLINARY TEAM IN PRIMARY CARE

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CERTIFICATE OF APPROVAL

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DEDICATION

This thesis is dedicated to my husband, Gary,
with all my heart.

ABSTRACT

DEVELOPING A MULTIDISCIPLINARY TEAM IN PRIMARY CARE

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The changing trends in health care are focusing copiously on the importance of prevention. However, research has shown that there is a lack of education and strategic programming to do this in primary care clinics despite the growing attention in medical journals. A structured multidisciplinary team in primary care can be influential in obtaining the services necessary for patients before the problems are unmanageable to be handled in an outpatient setting. The program introduced in this study has set role definitions based on the findings in the literature regarding each discipline involved. The team consists of the physician (general practitioner), social worker, dietitian, and nurse. The physician is the resource for patients to see medical specialists. Likewise, the social worker is the resource for assessing the psychosocial issues and making appropriate referrals which can cut down on the time physicians spend with patients for non-medical issues. Also, a teaching method is shown using a video as the instructional aid. Implications for social workers and managed care are discussed.

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CHAPTER 1

INTRODUCTION

Health Care Organizations nationwide have been changing to stress the need for outpatient management of complex patients and medical problems and to decrease the over-utilization of inpatient services by implementing new prevention programs.

From 1975 to 1990, spending in outpatient services increased by 420% (in constant 1990 dollars), while inpatient services increased by only 95% (U.S. Department of Health and Human Services: Congressional Budget Office, 1990). This divergence reflects the move away from inpatient care toward more outpatient health care services. Along with this shift to outpatient care is a change in health care philosophy, in which the need to reduce morbidity, risk, and cost makes early intervention important. This paradigm shift in health care in America is redirecting our attention away from individual episodes of acute illness to a continuum of care including prevention (Colone, 1993).

Providing high-quality, comprehensive care in the United States is increasingly challenging because of three dramatic trends: the aging of American society, the shortage of primary care physicians, and rising health care costs (Collier & Early, 1995). The group of Americans 65 years of age and older is increasing at twice the rate of the younger segment of our population (Rice & Estes, 1984). By the year 2020, those over 65 years of age will comprise 15% of

our total population. The rate of adults 80 years of age and older is growing at five times the rate of the total population (Jecker & Schneiderman, 1992). Eighty percent of those age 65 and older have one or more chronic conditions that require regular health care (Schneider & Guralnik, 1990).

The primary care physician shortage is another major challenge facing health care provision in the United States. In 1989, only 23 out of every 100 newly trained physicians chose to enter family or general practice. This has caused concern because 24,000 generalists in 1989 were over the age of 55. Only 34% of physicians today describe themselves as generalists and less than 25% of physicians will function as generalists in the next century if this trend continues (Colwill, 1992).

The rising cost for health care is the third challenge. Between 1976 and 1987, the increase in spending for medical care exceeded inflation by almost 80 % (Schneider & Guralnik, 1990). In 1960, national health care expenditures represented 5.3% of the gross national product (GNP); in 1970, 7.4%; and in 1985, 10.7% (Jecker & Schneiderman, 1992). By 1989, consumers, private insurers, and state and federal programs spent a record total of more than $604 billion dollars, or 11.6% of the GNP, on health care. The rate continued to rise, so that 2 years later 13% of the GNP was spent on health care (Darman, 1991). Spending is expected to reach 16% of the GNP by the year 2000 and 26% by 2030 (Darman, 1991). Based on Census Bureau statistics, the projected total cost of Medicare will nearly

double between 1987 and 2020 (Schneider & Guralnik, 1990). Medicare costs are projected to exceed 27% of the federal budget by 2025 (Darman, 1991). Currently, persons 65 years and over represent approximately 12% of the population, but they account for 33% of the nation's total personal health care expenditures (Jecker & Schneiderman, 1992). Given these challenges, changes need to be made in health care delivery.

Traditional health care has focused on the diagnosis and management of acute and chronic illnesses (Collier & Early, 1995). It is provided by physicians in the office or clinic setting. The physician typically sees the patient, generally with time constraints, and identifies medical problems. The primary care physician's focus is primarily on the medical management of the patient. Because of time constraints and the need for comprehensive assessments, physicians many times fail to uncover the actual functional or mental status of their patients. Therefore, it often fails to support patients in achieving maximum functional independence.

This study will show a model for a systematic program of multidisciplinary primary care which can be utilized in any medical center with a desire to increase outpatient services and decrease the number of admissions to the facility. A structured program could then be able to be tested in different primary care clinics to evaluate its efficiency to operate and determine whether it is a cost-effective alternative to inpatient care. An instructional aid to explain and teach this program will also be shown.

CHAPTER 2

REVIEW OF THE LITERATURE

There are four concerns, issues, or questions to be answered in the literature search: 1) What are the results (if any) of the research that was performed to test quality of services and cost-effectiveness using a multidisciplinary team approach in a primary care clinic? 2) If there are any results, was a standardized multidisciplinary program in place that could easily be transferred to another facility? 3) Are there any proven teaching methods that could be compiled together to create a formalized training program for health care providers in various disciplines? 4) What are the current trends in primary care?

Biopsychosocial & ecological systems

The perspective of the biopsychosocial and ecological systems models of intervention emphasizing the importance of the social and environmental aspects involved in providing health care is critical in an era of managed care. This is a constant challenge since psychosocial and environmental factors are easily lost in the midst of economic diligence (Resnick & Tighe, 1997).

Between 20% and 80% of primary care visits involve the "medicalization" of presenting problems that are frequently psychosocial in origin (Azzarto, 1993; Curiel, Brochstein, Cheney, & Adams, 1979; Ell & Morrison, 1981; Gropper, 1987; Mullaly, 1988).

Primary care physicians, both urban and rural, frequently fail to address the social, emotional, and psychological needs of their patients, despite the stated goal of providing a holistic approach to patient care (Badger, deGruy, Hartman, Plant, Leeper, Anderson et al., 1994; Badger, deGruy, Hartman, Plant, Leeper, Ficken et al., 1994; Goldberg, Jenkins, Miller, & Faragher, 1993). This is a significant problem because it is very well documented that a mental disorder—major depression—is the most prevalent disorder of any kind (mental or physical) in primary care (Hoeper, Nycz, Cleary, Regier, & Goldberg, 1979; Katon & Sullivan, 1990; Schulberg et al., 1985). Despite this, research performed over the past two decades has documented that underdiagnosis of depression and other mental disorders by primary care physicians is in the range of 50% to 80% (Katon & Sullivan, 1990; Schulberg, 1991).

Because of the great interest in developing ambulatory care components within medical school curricula, Papadakis and Kagawa (1993) felt there was a need for outcome data concerning such changes. They divided 40 third-year medical students into two groups. The first group was exposed to education in an ambulatory care clinic and the second group was not. T-tests of the students were used to determine whether there were statistically significant differences between the performances of the two groups. No significant difference was found between the two groups of students on the objective or subjective measures of evaluations,

although the diaries that the clinic group kept revealed that they were excited about the clinic experience.

Robbins, Cope, Campbell, and Vivell (1995) agree that there needs to be a developed consensus on proficiencies internal medicine residents should master in the areas of primary and managed care. Their study revealed that with the emphasis on primary care, there is a need for educational objectives. The method they utilized in their study provides educators with a benchmark to test the adequacy of their institutions' curricula in primary care.

Fullan (1995) says that education in ambulatory care needs to be very structured. Corcoran and Winslade (1994) discuss the confidentiality issues that are encountered when working with a care management team and what actions need to be followed.

Lack of primary care alternative

There have been many debates and struggles leading into the areas of which methods of care in primary care offers better quality of services and is cost-effective. Fitzgerald, Smith, Martin, Freedman, and Katz (1994) performed a descriptive study utilizing a case management technique which attempted to detect and fulfill unmet medical and social needs, intensify post-discharge care, identify and mobilize effective community services, and enhance primary care access. This technique was used at a Veterans Affairs Hospital both while patients were inpatients in the hospital as well as in the primary care clinics to see if it would

reduce the number of admissions or readmissions to the hospital. They conducted a randomized controlled trial which showed that intervention patients had more frequent visits per patient per month to the general medicine clinic (0.30 +/- 0.23 vs. 0.26 +/- 0.22, $p = .008$), but no significant differences between the two groups was detected in nonelective readmissions, readmission days, or total readmissions. Therefore, they concluded that frequent contacts for education, care, and accessibility by the team were ineffective in lowering costs. Nothing was stated in this article pertaining to the quality of care.

However, in a more recent study performed by Smith (1995) which utilized a multidisciplinary approach to case management, patient satisfaction increased from 4.43 to 4.84 (5-point Likert scale, $p < .0001$). Staff satisfaction increased from 4.3 to 6.24 (7-point Likert scale, $p < .001$). Re-admissions within 10 days of hospital discharge decreased by 28% ($p< .01$). Length of visit decreased by 9.5% ($p < .0001$). Continuity improved from 47% to 69% of visits to the primary care team ($p < .0001$). Smith felt that these results more than justified the staff time needed to convert to a multidisciplinary system.

In another current study, Smith, Goldman, Martin, Williamson, Weir, Beauchamp, and Ashcroft (1996) tested the hypothesis that the Department of Veterans Affairs (VA) hospitals would have substantial overutilization of acute care beds and services because of policies and education that emphasize inpatient care over ambulatory care. Reviewers from 24 randomly selected VA Hospitals

applied the Intensity, Severity, Discharge (ISD) criteria for appropriateness concurrently to a random sample of 2,432 admissions to acute medical, surgical, and psychiatry services. As a result of their explanatory study they found that one of the reasons for nonacute admissions into the hospital was a lack of an ambulatory care alternative.

Ashton, Weiss, Petersen, Wray, Menke, and Sickles (1994) suggest that the VA system is slowly improving; and that the reason for the number of inpatients declining is because they have been somewhat successful in shifting the focus of care from the hospital to the ambulatory care setting. Hao and Pegels (1994) argue that VA hospitals operate relatively inefficient and that it could be related to the lack of primary care services utilized.

Coast, Inglis, & Frankel (1996) used a standardized tool to outline the alternatives for admission into a medical center. General practitioner panels estimated that 8-14% of all admissions could have received alternative care. Urgent outpatient appointments were one of the main alternatives chosen by all panels. Sylvester (1996) responded to this study stating that the most efficient way to prevent over-utilization of inpatient beds is if the primary care team liaises with the hospital during the patient's admission.

Addressing the needs of patients

In order for primary care practitioners to address the needs of patients, health care needs cannot be defined as those that are strictly medical in nature.

Rather, the medical treatment of patients is always embedded in the context of social, psychological, cultural and environmental variables. Thus, it is appropriate to speak in terms of identifying social health care needs (Berkman et al., 1996).

.Increasing numbers of elderly patients previously cared for as inpatients are now being followed in outpatient clinics (American Hospital Association 1990-1991). Elderly patients receive more than 50% of total outpatient contacts (Freeborn, Pope, Mollooly & McFarland, 1990). Seventeen percent of the population over the age of 65 are significantly impaired in daily functioning. Sixty percent of this group live independently in the community (Fauri & Bradford, 1986; Maddox, 1987).

There were several opinions presented by nurses stating that they are trained to handle and coordinate the needs of the patients and do not necessarily need the multidisciplinary approach. Kerwick, Verkaaik, Hilyard, Wiley, Schnack, and St. Morris (1995) speak of nursing as "total quality management," and Brown and Waybrant (1988) argue that nurse practitioners are able to handle various patient problems including education, psychosocial assessments, and counseling without assistance from disciplines trained in each specific area. No study was performed to support this approach.

Another similar nursing article by White, Gundrum, Shearer, & Simmons (1994), discuss the role for case managers in the physician office. They also support the idea of one nurse handling all of the complex areas of patient care

without input from other disciplines. They will make referrals as needed but want to coordinate all of the assessments.

A limitation of these approaches is that other disciplines are actually trained in areas such as counseling and making psychosocial assessments, therefore, depending solely on nursing would not necessarily be beneficial to the patient and in turn may not be cost-effective.

Trends in cutting health care costs are encouraging health care delivery systems to adopt alternative models of patient care. Collier and Early (1995) report on one such model, the complementary practice model, which incorporates a team approach to geriatric case management. It targets the frail elderly who are near the end of life, or are at highest risk for either hospitalization or cognitive decline. It includes a multidisciplinary team consisting of the patient, family, physician, social worker, nurse practitioner, and registered nurse as core team members.

A possible limitation in this model is that it would be difficult to bring the entire team together for conferences. For example, families do not always accompany patients for their appointments. Therefore, this approach is used as more of an outpatient home-based model instead of a primary care clinic model.

A survey performed in California by Hirsch and Winograd (1992) finished with no concrete results. One group of patients in the experiment received multidisciplinary evaluations and the other group received routine evaluation.

They agreed that their results did not provide any insight into the clinical effects of the team approach because their results were very variable.

There is obviously still debate over these complex issues but it appears that the more recent articles show the benefits both in quality of service as well as in cost-effectiveness utilizing a multidisciplinary team method in primary care clinics.

Training for social workers

Social work's involvement in primary care is not new, as demonstrated by the Cincinnati Social Unit. This unit functioned from 1917 to 1920 (Betten & Austin, 1977). The New York State Charities Aid Association, focused on public health issues from 1893 to 1948 (Kane, 1985). The Henry Street Settlement House of New York, assisted with the control of infectious diseases (Kane, 1985).

Social workers are beginning to focus on the need for their own training in primary care clinics and in the future will try to devise curriculum to use in schools of social work (Siefert, Jayaratne, & Martin, 1992). The article did not state what kind of curriculum would be utilized, but it did discuss ways of educating social workers on how to train physicians to make psychosocial assessments and when to refer problems to social work.

Zayas and Dyche (1992) also give step-by-step teaching tools on how social workers can educate internal medicine residents working in a primary care clinic to assess psychosocial problems and when to refer their patients to a social worker.

This article was based on random examples in one hospital. Valente (1995) suggests that comprehensive patient education programs can be successful if taught formally to health care workers.

A screening instrument for underserved rural and urban primary care clinics was introduced by Resnick and Tighe (1997). It was developed in part with interviews with patients along with staff and agency input. It is a self administered social work screening instrument with 26 yes-no questions that facilitates autonomous social work case finding.

Training physicians on what makes an appropriate referral to social work could be beneficial; however, if social workers are trained to make psychosocial assessments, why should they train physicians how to do them. General practitioners generally see a patient every 12-15 minutes, providing inadequate time to diagnose or treat mental disorders or psychosocial issues (Eisenberg, 1992). In a survey conducted by Rost, Humphrey, & Kelleher (1994), 30% of rural primary care physicians cited lack of time as the most significant barrier to care. Thus it is ineffectual to ask physicians to recognize disorders they have inadequate time to diagnose (Zimmerman & Wienckowski, 1991).

In a study performed by Badger, Ackerson, Buttell, and Rand (1997), physicians' attitudes towards social workers and the endorsement of social work roles were examined. Despite the combined effect of high prevalence of significant morbidity associated with psychosocial problems among rural primary

care patients and physicians' limited time to manage these problems (Rost, Humphrey, & Kelleher, 1994), only about 17% of physicians have considered having a social worker for their practice. Similarly, only one-third of this sample expressed interest in participating in a trial of integrated social work. Several physicians described their patient clientele as "too healthy" to provide sufficient reason for a full-time integrated social worker. The authors stated that a more disturbing interpretation could be that physicians think that social workers are neither competent to screen for mental disorders nor qualified to provide psychotherapy.

It has been shown in various studies that the provision of psychosocial services to patients by social workers can be cost effective by decreasing the utilization of visits to the physician, particularly those that usually present with nonmedical problems (Baume, 1972; Borus, 1976; Liptzin et al., 1980).

Discussion/Summary of the literature

Although many different disciplines (i.e. physicians, social workers, nurses) agreed that structured interdisciplinary programming would be effective in primary care, there was little agreement regarding how to operate this (Collier & Early, 1995; Kerwick, Verkaaik, Hilyard, Wiley, Schnack, & St. Morris, 1995; Siefert, Jayaratne, & Martin, 1992; Zayas & Dyche, 1992). One of the primary limitations with the ideas presented in the literature is the various disciplines have researched the issue of prevention in primary care within their own career area and do not

cross-over their findings to other journals to see if it is a viable solution for other involved disciplines. In order to integrate the various ideas each discipline has regarding the team approach, they need to consolidate their ideas with other disciplines of which the solutions would directly affect.

It was also shown that very few structured multidisciplinary primary care programs have been developed that can be utilized in different health care settings and then tested to find out if they are effective or efficient (Badger, Ackerson, Buttell, & Rand, 1997; Rost, Humphrey, & Kelleher, 1994). It is important to note that many of the articles were based on opinions or untested random observations to prove the authors' own personal ideas, so the information could be very biased.

The idea that physicians need to be trained on how to assess for psychosocial, psychological or other non-medical issues appeared many times in the literature and is unrealistic. The managed care guidelines for the amount of time physicians can spend with their patients in a primary care clinic is 12-15 minutes. This includes the medical assessment, examination, writing out the prescriptions, and documentation. Perhaps this is tangible with patients who are healthy over-all and just want a check-up, but with patients who tend to have several complex medical issues, (i.e. geriatrics, HIV/AIDS, veterans, etc.), expecting that physicians would be physically able to do the extra non-medical assessments is unrealistic, even if they are trained and willing.

One interesting concept that repeatedly surfaced in this review was the fact that almost every discipline viewed themselves at some point as the "core" of the team and others considered themselves capable of handling the many multidisciplinary problems without any input from other professionals at all. This very common problem could also be solved with a structured program where special care would be taken to define the roles of the various professionals so there are not any "turf" issues or confusion regarding where the responsibility lies.

This literature search was very informational because it gave much insight into the past and future of primary care. It has given working knowledge on the various ingredients necessary to design an effective multidisciplinary team and offered suggestions on how to coordinate a multidisciplinary primary care team from many different perspectives. A method for a teaching and implementation video will also be presented later in this study.

CHAPTER 3

THEORETICAL FRAMEWORK

The managed care framework is an idea that is growing increasingly more popular because of it's emphasis on prevention and "managing" the total needs of the patient and not just on medical problems. Managed Care can be defined as an "organized system of care that seeks to influence the selection and utilization of health services (including preventive care) of an enrolled population and ensures that care is provided in a high-quality, cost-effective manner (Federa & Camp, 1994)."

The multidisciplinary care team developed in this study stems from the managed care philosophy in that if the whole person is managed, the prevention of medical crises is more attainable. This study will apply the managed care framework to a potential primary care multidisciplinary team. Primary care is not necessarily synonymous with managed care (Starfield, 1993). In most Western industrialized nations, primary care is a well defined entity, usually referred to as general practice. In the United States, there is considerable confusion concerning the unique features of primary care (Starfield, 1993). The arrival of managed care with its emphasis on a "gatekeeper function," has helped in clarifying the situation.

Managed care organizations have hired the various staff needed to fully care for all aspects of patient care in primary care but have not structured the operation. They hold that the initial assessment for non-medical issues be

performed by the primary care physician and then if he/she deems the patient could benefit from ancillary services, he/she will make the appropriate referral. The ironic piece is that the rigid guidelines managed care places on physicians regarding the amount of time they can spend with their patients do not allow for such "prevention" to be taking place.

Questions regarding how well managed care actually works have taken on new urgency because managed care has been integrated into the United States so rapidly. The impetus behind managed care began when employers tried to find a way to reduce their expenses for their workers' health benefits (Glazer, 1996).

Managed care relies on a general practitioner to act as the "gatekeeper" in deciding whether a patient is referred to a specialist (Adams, 1995). As mentioned above, managed care discusses the importance of looking at all issues pertaining to the health of the patients (physical, mental, emotional). Interestingly, the "gatekeeping" between primary care physicians and specialists is for medical problems only. Therefore, the program introduced in this study uses the social worker as the "gatekeeper" of psychosocial problems. It was shown in the literature review that undetected psychosocial issues can augment medical problems and in turn, increase health care costs. The managed care framework between physicians and specialists is used similarly in this study regarding the social worker and other ancillary services.

CHAPTER 4

METHODOLOGY

In order to define and explain how a primary care multidisciplinary team can work using the Managed Care time guidelines, and based upon a comprehensive literature review taking in the different perspectives of the various disciplines involved, a program was developed. In this program it is explained how to coordinate comprehensive care of patients in any medical center with a desire to increase outpatient services and decrease the number of admissions to the facility. It will also be structured such that the same program can be implemented in various settings so there would not be as much variability to affect the reliability of future evaluation.

In a sense, two methodologies will be presented. The first one will be the design of the program. The second one is a script for a video showing how to implement such a program. A video was selected as a means of teaching due to the fact that it can be presented at one time to an interested group of individuals with the content and design being demonstrated with examples and illustrations.

There will be no independent and dependent variables to define because this project designs and describes a program that uses the managed care guidelines. The key concepts for this project will be: primary care, outpatient/ambulatory care, and multidisciplinary team. Primary care is any medical care given to a patient in an outpatient clinic by internal medicine, family practice, or pediatric

physicians. Outpatient/Ambulatory care is any care given to a patient who is not admitted into the hospital. Multidisciplinary team for this program will be a group of individuals caring for the same patients from at least the following disciplines: medicine (physicians), social work, dietary/nutrition and nursing. Optional disciplines can include psychology, pharmacy, psychiatry, etc.

Study Design of the Program

It is important to note that this program is designed for clinics that are utilizing a managed care framework (i.e. Health Maintenance Organizations [HMOs]). However, this program can also work in other non-HMO hospitals/clinics. In a HMO the ancillary services will not be paid on a fee-for-service basis. Instead, they will be salaried on a full/part time basis (depending on the organization) and since the HMO is its own organization, it will not need to "pay out" for these extra services. For other non-HMO organizations, the ancillary services can be reimbursed from most private insurance companies.

Social workers will have the role of being the "first responders" for the psychosocial needs of the patients. When the patients come in for their regularly scheduled appointments, the nurse will give the patients a social work assessment form to fill out after the initial nursing examination. The assessment is based on various studies shown in the literature that have been compiled together (see appendix A). The social worker will review the issues that would make the patient "high risk" for future and more severe problems based on the results of the

completed assessment. The goal is to detect these issues early before they become unmanageable for an outpatient setting and consequently require admission to the medical center. If patients reveal information that the social worker deems is "high risk" or questionable, he/she will probe further to find out if the issue is a problem or even potential problem. Also, the social worker will spend some time talking to the patient about any issues the patient wants to discuss.

The social worker represented on the team will be a Licensed Independent Clinical Social Worker (LICSW) because much of the work will require the clinical skills acquired from advanced training. The LICSW will perform the clinical assessment and determine which interventions, if any, are necessary. He/She will also be responsible for making referrals to other ancillary services based on the assessment. The LICSW will make referrals to a Licensed Social Worker (LSW) for interventions that are non-clinical in nature (i.e. arranging home care, nursing home, etc.). However, for patients who need clinical interventions (i.e. therapy), the LICSW will handle those aspects of the case. Separating the cases between the LICSW and LSW will be cost-effective because in many medical centers masters prepared social workers are performing duties that bachelors prepared social workers are qualified to do.

Physicians have notoriously been the ones to make referrals to ancillary services in the past. It has been common to hear the phrase, "Have you received a

referral from your primary physician?" In this program the only referrals the physicians will have to make are to specialist physicians. Referrals for a dietitian, psychologist, and social work services can be made by the social worker depending on what his/her assessment is of the patient. However, if an issue related to the patient's medical care comes up during the appointment with the physician but was not discussed during the social work assessment, the physician can refer the patient back to the social worker for follow-up.

An example of an appropriate referral from physician to social worker might be a common issue amongst patients with diabetes. Diabetic compliance with medications is a challenge that often interferes with staying healthy. Patients are typically told by their physician to take their medications, but the real issue is sometimes missed regarding why they were not doing so. Failure to address the real issues costs thousands of dollars because the problem gets worse. Consequently, the patient might need to be admitted which is very costly. A more serious consequence is: what happens when the patient's condition is stabilized in the hospital and he/she returns home? If the patient has still not been worked with to find out what the issues are to prevent his/her compliance with medications, he/she will return to be admitted. This is an example of how the program uses patient centered treatment with a cost-effective outcome. Social work intervenes to work with the patient on why they are not taking their medications.

The dietitian can receive referrals from the physician, social worker, or nurse. Many medical and psychosocial issues/problems are directly related to nutrition and exercise. This is a critical piece that has notoriously been missed as a viable prevention area.

The registered nurse (RN) on the team is responsible for the initial medical assessment when patients come in for their medical appointment. He/She will take the patient's temperature, check the blood pressure, height, weight, etc. If an issue comes up during the nursing assessment, the RN can refer to other members of the team. Also if referrals are made to community resources by the social worker, the RN will be responsible for giving appropriate professionals medical information as needed.

At the end of each clinic day, the team will meet for 30 minutes to discuss with one another what referrals were made and what interventions were done. Also, if no referrals were made but there is a potential problem with a patient, the issue can be brought to the team, discussed and then a plan can be implemented to address the problems based on the collaborative brainstorming of suggestions from the team.

Study Design of the Video

The primary care clinic at the Veterans Affairs Medical Center in Minneapolis, MN (MVAMC) allowed the taping to occur in the facility. The taping of raw footage occurred March 19, 1997 from 9:00-6:30 (see Appendix B

for complete listing and order of video footage). Individuals willing to volunteer their time were cast in various roles. It is important to point out that none of the patient/family systems used in the video are real patients. They were merely actors with experience in the simulation of real life situations.

The edited video (see Appendix C) begins with a 30-second introduction of short clips of various activities occurring in the hospital. There is a 30-second made for video jingle with no words playing in the background; and on each downbeat, the scene changes to something else. The last scene is of a team meeting with the title juxtaposed across the screen—"Developing A Multidisciplinary Primary Care Team." When the music ends, a graphic of clouds changes the scene to just the title with blue writing on a black background.

During the video, narration is utilized to cover what discussion was really occurring both to protect the problems of patients that were simulated and to explain things as they are occurring for the viewers. The role of each discipline is explained, which will assist future teams to not become confused with who should be responsible for what.

The second piece shows a patient "Laura" sitting in the waiting room reading a magazine. The nurse walks in and calls her name and Laura gets up and walks out with her. This is the only piece on the video in which the sound is not erased. We actually hear the nurse call "Laura Price" out loud. In the editing booth, the volume of the waiting room is slowly decreased at that point with the

volume control and video jingle music is brought up. The narration begins almost simultaneously with the music.

Next, there is a puzzle graphic which "puzzles in" a new scene. The puzzle graphic was specifically chosen because each time a new team player is presented, they are introduced by a puzzle being pieced together. As can be seen in the script, reference is made to the team members all being pieces of a puzzle. The scene being introduced at this point is with the social workers. Two social workers are shown talking to clients. The first one is a social worker walking down the hallway and talking to a patient. As the narration explaining the role of social work continues, the scene will change to a social worker counseling a patient and his wife.

Next, the scene changes and the physician is introduced with the puzzle graphic. There are two scenes comprised of different individuals being examined by the physician. The first scene is more of a traditional exam (i.e. checking ears, throat, glands, etc.). The second one shows the patient and physician talking at length with the physician taking detailed notes. This is used to illustrate the inefficiency of time and money because the narration explains that the physician is discussing psychosocial issues that could be addressed by the social worker.

At this time in the video another puzzle graphic introduces the dietitian talking to two different patients. The dietitian uses graphs, charts, pamphlets, and

even rubber meat to show serving sizes to the patients. It is assumed in the narration that the patient are seeing the dietitian for a variety of reasons.

The final segment of the video includes selected footage of an ambiguous meeting occurring at the MVAMC with the sound erased. Some of the members present were seen earlier in the video with patients. The narration explains how the different disciplines come together for a "meeting of the minds" to solve problems of complex patients. As the scene is unfolding, the narration will be explaining how referrals are made and how follow-up is accomplished.

Study Population

Since there is no experiment taking place there is no study population. However, the program is intended to target managed care administrators as well as physicians, social workers, dietitians, or nurses in primary care clinics.

Data Analysis/Editing Process

The editing for this video was done in the Augsburg College video editing room. Fifty hours of editing have been completed primarily utilizing the toaster system. First, all of the raw footage was watched and labeled in terms of determining the length of each scene (see Appendix B). The best pieces from the raw footage were edited together for the final product. Background video music was interjected throughout to maintain interest.

The program itself was not analyzed as part of this project because it is not being implemented at present. However, in chapter 4 the process will be discussed.

Human Subjects

Contact was made to the Augsburg Institutional Review Board chair and this project was exempt from needing authorization secondary to the fact that no human subjects are being used for testing. Everyone will be acting their roles with simulated cases that are not real. The staff meetings may be recorded live; but in these cases, narration will cover the discussion so as to protect all patients' privacy. All participants are volunteer staff from the MVAMC or various professional volunteer actors from the community.

CHAPTER 5

RESULTS

Results of the program

The description of the multidisciplinary primary care team presented in this study was discussed in detail in chapter 3. The model for the team was not implemented or tested in any way and subsequently, no data or results were obtained. This study was done to investigate the issues in primary care today and what role various disciplines can have in the prevention of medical and psychosocial problems. It was shown in the literature review that the past concentration solely on medical problems did not decrease the health care costs secondary to the fact that prevention needs to begin with non-medical problems.

The program introduced in this study focuses on the prevention of all health related problems. Since medical issues can surface because of psychosocial problems, the managed care framework was adopted to present a social work gatekeeper for psychosocial prevention in primary care similar to that of the general medical practitioner with other medical specialists.

Results of the video

The second idea that was introduced in this study was the instructional aid showing how to construct this program in a primary care clinic. A video was developed and the steps taken were described in detail in chapter 3.

The results of the video are known by deciding if, or to what extent, the goals of the video were reached. The goals and results were as follows:

1. *Develop a plan and script for the video*

A plan and script were developed in conjunction with the design of the program itself. After the program was designed, a script was written based on the findings of that segment of the study (Appendix C). After the script was written, a plan was devised regarding how to implement the video. The methodology of this plan was presented in chapter three and then implemented.

2. *Recruit volunteers to act out various scenes on video*

Individuals from within the Minneapolis Veterans Affairs Medical Center (MVAMC) were recruited to represent staff on the multidisciplinary team. Various actors from the outside were recruited to represent patients. Recruitment was done by personally asking each individual.

3. *Edit video*

The editing took place in the audiovisual department at Augsburg College. The raw footage was compiled and edited as per the script. Music was added and the script has been written to be placed on the video. Many graphics were used to stress certain

points and maintain interest. A total of 78 hours were spent editing the video.

4. *The video could be used as an effective instructional aid*

The video explains in detail how to construct a multidisciplinary primary care team. The effectiveness of the video is unknown at present because it has not been tested. A group of individuals who could potentially utilize this method would need to watch the video and offer feedback in order to obtain the results to this goal.

Although the information has been gathered, testing needs to be done to see if this program is efficient and cost-effective. Patient and staff satisfaction regarding this approach would also be both insightful and beneficial. In the last chapter, these results will be discussed. Also, implications of these results for social work and managed care will be considered.

CHAPTER 6

DISCUSSION

This study investigated the trends and challenges in primary care and offered a new approach of offering services that can be cost effective and time efficient. A video was also presented to illustrate and explain the roles of the staff and the organization of the program for any primary care clinic.

Producing a video is a time consuming endeavor. However, the final product can be helpful in explaining and illustrating points that are easier to understand and communicate than those solely in writing. Furthermore, a video can be an inexpensive project if volunteers are utilized. In this project many volunteers were involved in various roles.

In this final chapter, limitations of the study will be discussed as well as the implications for managed care and social work.

Strengths & Limitations of Study

The issues of multidisciplinary teams in primary care and the efficiency of primary care clinics are relatively new topics. The research is recent and very few sound methods are presented. It is difficult to pilot the implementation of methods such as the one presented partly because our society is slow to accept non-medical prevention as a viable cost containment.

This study had a significant amount of limitations simply due to the fact that it is a novice idea with very little past research having been done on any

similar topics. Because the literature does not fit specifically with the ideas presented in this project, it was instead used to "pioneer" off to a different line of thinking. Furthermore, a primary care clinic would need to allow the program to take place in its' facility to test and evaluate the effectiveness.

Unfortunately, many individuals who could benefit from such a program are unable to simply because of insurance or financial difficulties. Therefore, this program cannot always reach those who particularly need the services. This is more of a limitation of our current health care system and not something that was addressed in this multidisciplinary program. However, once a patient finds a way to the clinic, the social worker can assist with financial constraints and arranging services.

This is a structured program that can be incorporated into many different settings. Therefore, because of it being the same program, there would not be as much variability to affect the reliability of future testing and evaluation of the effectiveness of the program.

Implications for social work & managed care

"Prevention in primary care," are the health care buzzwords of today. Managed care has been influential in adopting this phrase and building clinics around it. However, as shown earlier in this study, they have been ineffective in organizing the clinics in such a way to make "prevention" tangible. This study

shows a method that allows the managed care framework to work proactively with the various disciplines.

Because of the skills in process, communication, and assessment, social workers are excellent candidates for not only working with patients but to be involved in the planning and designing of programs. Much of what social workers discuss and seek to improve is the process of organizations and the communication within the organization. In particular, health care organizations are in need of individuals who understand process and results because of the velocity of change occurring in the industry and the degree to which the consumers are dissatisfied.

Conclusions

As discussed in the strengths and limitations section, because this is a new program, it would need further testing and research to prove or disprove the effectiveness or efficiency. As health care organizations are rapidly changing to fit the needs of fiscal requirements and to ensure excellent health care, on-going research into these topics needs to move at the same velocity. Changes are not going to occur without critical thinking that incorporates the views and opinions of all disciplines in health care. In other words, research regarding teamwork cannot effectively be done until the prior research of all involved members is consolidated. As can be seen in the literature review presented in this study, lack of communication between disciplines was key in the failure of several programs. The program presented in this study fused the different viewpoints together and

showed a new and organized method to working in a primary care clinic that encompasses the expertise of the different disciplines.

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APPENDIX A

EXAMPLE OF A SOCIAL WORK ASSESSMENT

Please complete this assessment form by answering "Yes" if the situation applies to you; and "no" if the situation does not apply. Please ask for assistance if you need help or do not understand a question and return the form to the receptionist when completed.

I do not have health insurance Yes_____No_____
I am homeless or living in a shelter Yes_____No_____
I need help with housing Yes_____No_____
I am unemployed and/or trying to find a job Yes_____No_____
I need to apply for food stamps Yes_____No_____
I cannot pay for my medical bills Yes_____No_____
I am over age 65 and need help Yes_____No_____
I have been diagnosed with a serious illness Yes_____No_____
If yes, are you having trouble dealing with your illness? Yes_____No_____
My children are not up to date on immunizations Yes_____No_____
I am under age 18 and not attending school Yes_____No_____
I have received psychiatric treatment now or in the past Yes_____No_____
I am involved with the court system Yes_____No_____
I want information about substance abuse programs Yes_____No_____
I want to learn more about birth control or condoms Yes_____No_____
I want help managing my child's behavior Yes_____No_____

How often do you drink alcohol? _____
Do you take illegal drugs? Yes_____No_____; If yes, how often?_____

For Women Only:

I am pregnant Yes_____No_____
If yes, answer the following questions; if no, please return this form to the receptionist;
I am not receiving prenatal care Yes_____No_____
I have no health insurance Yes_____No_____
I need to apply for WIC (Supplemental Food Program for Women, Infants, and Children) Yes_____No_____

APPENDIX B

LIST OF RAW FOOTAGE

0:00-2:07 - outpatient entrance
2:09-2:19 - visitor entrance pan
2:20-2:40 - information center pan
2:40-2:52 - American flag zoom
2:53-3:12 - x-ray sign zoom
3:13-3:31 - 1st floor hallway sign & map
4:00-5:05 - specialty clinic sign

5:06-5:28 - 2 shots w/ L and M with butter spray
5:28-5:41 - 2 shots w/ L & M w/ meat
5:42-7:08 - CU hand pointing to nutrition chart
7:25-7:40 - pull out from CU on nutrition info.
7:50-8:10 - 2 shots w/ rubber beef
8:10-8:25 - OS Monica
8:25-8:41 - OS Laura

8:42-9:05 - 2 shots w/ L & Mui
9:20-9:35 - OS Mui
9:37-9:41 - zoom on Mui
9:47-9:52 - zoom out from Mui to OS
9:52-9:56 - OS Mui taking off stethoscope/smiling
9:57-10:09 - 2 shots Mui w/ stethoscope
10:10-10:26 - Mui & L w/ stethoscope
10:27-10:55 - Mui checking L's ears
10:55-11:20 - OS Mui
11:45-12:15 - OS L

12:41-13:17 - R & N @ table
13:19-13:51 - pan from R & N to nutrition chart
13:56-14:05 - pan from nutrition chart to N & R
14:26-14:57 - CU of R looking right
15:40-15:46 - CU pan from N to R smiling
16:24-16:30 - CU on "cut fat sheet"
16:30-16:44 - zoom out from sheet

17:00-17:20 - CU profile of T looking right
17:50-17:59 - CU pan from T to M

18:00-18:11 - 2 shots of T& M
18:12-18:40 - CU tilt up & down of T looking @ sheet
19:05-19:20 - OS Monica
19:22-19:52 - tilt from OS M to nutrition sheet
20:17-20:19 - focus on M name plate
20:30-20:40 - M pushing T down hallway
21:20-21:40 - M pushing T in room

22:15-23:00 - Meg & L enter the room
23:08-23:28 - 2 shots OS Meg picking up paper
23:30-23:50 - tilt up from Meg's notes to L
23:56-24:07 - tilt up from Meg's notes to her face
24:12-24:23 - tilt down from L to Meg's notes
24:30-24:48 - OS CU Meg
24:50-25:30 - Meg & L come in—Meg picks up paper

25:35-25:43 - hallway shot
25:57-26:31 - D comes in room—A sitting reading magazine
26:32-27:28 - OS A; D checking A'S ears & throat
27:29-27:55 - CU of Don
27:56-28:21 - CU pan from D to Al checking breathing
28:26-28:40 - 2 shots D & A talking
28:40-29:00 - CU A getting glands checked; pan D smiling

29:10-29:20 - hallway pan
29:25-29:41 - L & C walking in hall turning corner
29:50-29:58 - pan across hallway w/ lots of people
20:08-30:20 - nurse calling L in waiting room

31:50-32:28 - T, K, & Dave entering Dave's office
34:20-34:42 - CU pan from K to Dave to T to Dave
35:12-35:30 - CU pan from Dave to T

36:30-36:40 - CU on Meg
37:04-37:40 - Gay speaking
38:20-38:25 - CU of N
38:39-38:45 - focus from CU N to CU C
39:52-40:13 - CU of Mui—zoom out to table conversation
40:33-40:37 - other side of table
40:40-41:00 - CU of D—ends w/ pan to Meg
36:00-36:04 - full shot of meeting

41:55-42:06 - B walking towards door
42:07-42:46 - B walks in; begins examining T
42:50-43:05 - B checking T's ears
43:05-43:30 - B checks T's reflexes
44:06-44:18 - OS B checking T's throat & ears
44:18-44:33 - OS T having throat checked
44:35-44:44 - 2 shots B checking T's heart
44:43-44:52 - 2 shots CU B checking T's heart
45:42-46:14 - B finishing w/ stethoscope; sits w/ notepad; gets up & leaves
46:15-46:37 - OS T talking to B taking notes
47:00-47:30 - B finishes exam; sits down w/ paper & talks w/ T
47:55-48:10 - OS B taking notes
48:25-48:29 - T looking left
48:30-48:57 - OS T talking to B; B taking notes

49:00-49:02 - tilt up to surgical waiting sign
49:39-49:41 - social worker sign

List of Abbreviations

CU - close-up
OS - over the shoulder shot
M - Monica
L - Laura
B - Lynn
R - Ray
N - Nicole
T - Terry
D - Don
A - Al
C - Cindy

APPENDIX C

SCRIPT FOR THE VIDEO

Introduction (30 seconds)

(music begins; short clips are shown in order on each downbeat of the music as follows):

-van pulling away from hospital with a fast zoom on "Outpatient Entrance" sign;

-zoom on "Specialty Clinic 1A" sign;

-nurses and social worker walking in hallway;

-M. D. with stethoscope;

-"X-Ray" sign;

-M. D. shaking hands with patient;

-dietitian talking with patient;

-social worker walking briskly down hallway;

-staff member giving presentation;

-M. D. checking patient's ears;

-M. D. sitting talking with patient;

-still shot of a meeting with different disciplines present

Part I

(Nurse walks in waiting room holding chart and calls out "Laura Price;" "Laura" puts magazine down and walks out with nurse; natural background sound from waiting room is ceased by lowering volume and bringing up music and narration)

Narration: Health care organizations nationwide have been changing to stress the need for outpatient management of complex patients and medical problems and to

decrease the over-utilization of inpatient services by implementing new prevention programs. This video will show one model for a systematic program of multidisciplinary primary care which can be utilized in any medical center with a desire to increase outpatient services and decrease the number of admissions to the facility...*(as patient walks with nurse)*...The registered nurse on the team is responsible for finding out the reason for the patient coming to see the doctor. The nurse will take the patient's temperature, check blood pressure, height, weight, etc. After this brief assessment, the nurse gives the patient the social work assessment to fill out. The nurse alerts the social worker if the patient needs help filling it out. Later, if the social worker makes referrals for the patient, the nurse is responsible for giving appropriate professionals medical information as needed.

Part II

Narration: Health care literature speaks of the primary care physician as being the "gatekeeper" for referrals to various specialists and other ancillary services. In this model, the primary care social worker *(puzzle graphic displays social worker talking with a patient and his wife)* makes initial psychosocial assessments on all patients before they see the physician. The social worker uses the answers to the standard assessment that the nurse gave to the patient to begin the assessment. If the patient seems to have no issues that could interfere with their medical care, no intervention is necessary. However, if counseling is recommended, the social

worker will make an appointment with the patient. If community resources are needed, the social worker will refer the patient to the social work assistant for intervention.

Part III

(puzzle graphic introduces physician examining a patient)

Narration: The managed care guidelines for the amount of time physicians can spend with their patients in a primary care clinic is 15-20 minutes. This includes the medical assessment, examination, writing out the prescriptions, and documentation. Perhaps this is tangible with patients who are healthy over-all and just need a regular check-up...*(graphic changes scene to a different physician sitting and talking with a patient)*...but with patients who tend to have several complex medical issues, expecting physicians to perform medical and non-medical assessments is unrealistic, even if they are trained and willing. The psychosocial assessments could be addressed by the social worker which would be more efficient and cost-effective.

Part IV

(puzzle graphic introduces dietitian talking to a patient; the dietitian has many charts and pamphlets for explanations)

Narration: The dietitian is a newer addition to the primary care team. Many medical and psychosocial problems are directly related to nutrition and exercise.

This is a critical piece that has notoriously been missed as a viable prevention area in primary care. The dietitian can receive referrals from the physician, social worker, or nurse.

Part V

(puzzle graphic introduces the entire primary care team sitting around a table talking)

Narration: At the end of the clinic day, the various members of the primary care team discussed come together to discuss issues regarding complex patients. Problem solving occurs as various referrals are made to one another.

Conclusion

(music heard at the beginning begins playing again; puzzle graphic begins "puzzling" the different team members in and out simultaneously)

Narration: As the various parts of the primary care team are pieced together, effective care can be offered to each patient. Each discipline represented on the team is performing the duties in which they were trained. The end result is organized health care with a goal to assess for potential problems that can be solved in a primary care setting.

RUN TIME: 6 MINUTES, 47 SECONDS